Results: 7 cases were treated. Mean age at diagnosis was 67 (± 11.1). There were 4 (57%) males. Fistulae developed post-oesophagectomy in 3 (43%), secondary to mediastinal malignancy in 3 (43%) and following stenting of oesophageal rupture in 1 (14%). All patients with post-oesophagectomy fistula (3) were treated with pedicled intercostal flap repair of the airway, with takedown of the oesophageal conduit. One initially underwent attempted oesophageal stenting. 2 (66%) of these were subsequently reconstructed, 1 (33%) died of disease recurrence before reconstruction. Other pathologies were treated by oesophageal stenting, tracheal stenting or both. One subsequently underwent pedicled latissimus dorsi airway repair and oesophagectomy. 30-day mortality was 0. Overall survival at 4 years was 65–70%.
Conclusion: Peri-operative mortality in airway-oesophageal fistula is low with modern management. These results mandate larger studies to explore the relationship between aetiology, treatment and outcome in airway-oesophageal fistulae.

0272: DOES ADDITION OF A PERICARDIAL DRAIN IN PATIENTS UNDERGOING ISOLATED AORTIC VALVE REPLACEMENT REDUCE POST-OPERATIVE COMPLICATION: A COMPARATIVE STUDY OF SINGLE VERSUS TWO DRAINS IN THE EARLY POST-OPERATIVE PERIOD?

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Aim: Some surgeons prefer introducing 2 drains post isolated Aortic valve replacement (IAVR) to facilitate better drainage and decrease the incidence of post-operative tamponade. The aim of the study was to compare the efficacy of single-drain versus two-drains in our centre.
Methods: 230 patients who underwent IAVR between January 2012–April 2013 were identified from the departmental database and included in the analysis. 4 surgeons prefer placing two-drains post-surgery, while 2 surgeons prefer single-drain. 120 patients had two-drains (one- mediastinal and one-pericardial), while78 had single-mediastinal drain. 32 patients were excluded from the analysis due to insertion of pleural drain.
Results: 198 patients were included in the study, 60.6% had two-drains, while 39.4%single-drain. No difference in the demographic, bypass or aortic cross clamp-time between the groups. Significant differenceswas observed in 6 hours (two-drain: one-drain Median: 350 mls vs 170 mls; $p < 0.05$); 24 hours (650 mls vs 380 mls; $p < 0.05$) and total drainage (713 mls vs 445 mls; $p < 0.05$). There was no difference in the incidence of re-opening for bleeding or cardiac tamponade (6.65% vs 3.85%; $p = 0.53$).
Conclusion: Our results suggest that single-drain is effective, with significant less blood loss, and no increased incidence of reopening or cardiac tamponade.

0330: AN AUDIT OF SURGICAL LUNG BIOPSY IN THE MANAGEMENT OF INTERSTITIAL LUNG DISEASE

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Aim: To audit practice of surgical lung biopsy in management of Interstitial Lung Disease (ILD) at our institution.
Methods: Standards established based on NICE guidance. Patients undergoing surgical lung biopsy (April-October 2013) identified retrospectively from our database. Data obtained from clinic letters, radiology and histology reports, and ONS. Patient demographics, MDT decision-making, pre-operative patient discussion, operative variables and subsequent management were assessed.
Results: 35 patients referred from 11 hospitals underwent lung biopsy. 24 (69%) patients were discussed at MDT but only 10 (29%) at specialist ILD MDT. Pre-operative discussion documented likelihood of diagnosis in 12 (34%), benefit of diagnosis in 23 (66%) and risk of death in 21 (60%). All procedures were VATS but biopsies obtained from all lobes in only 15 (43%). HRCT findings correlated with histological diagnosis in only 17 (49%). Mortality was 3% at 30 days and 9% at 1 year. 10 (29%) patients experienced morbidity, most commonly wound infection or chronic pain. Management changed in only 9 (26%) patients due to histological findings.
Conclusion: Radiology often did not correlate with histology reinforcing the utility of surgical lung biopsy; although the diagnosis infrequently impacted patient management. We recommend mandating specialist ILD MDT discussion to aid patient selection.

0396: USE OF LEFT INTERNAL MAMMARY ARTERY (LIMA) TO LEFT ANTERIOR DESCENDING ARTERY (LAD) IN FIRST TIME CORONARY ARTERY BYPASS GRAFTING (CABG)

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Aim: It is widely accepted that using LIMA as a bypass graft for LAD artery is associated with a better outcome than using the Long Saphenous vein. We aimed to review all isolated first time CABG operations 01/04/2010–31/03/201, and assess the percentage of cases where LIMA graft was not used and the reasons for this. 100% of first time CABGs should have LIMA to LAD graft. The reason for not using LIMA to LAD should be documented in all cases.
Methods: A retrospective electronic database search was performed. Electronic operation notes and patient records were examined. Data was then categorized and analyzed per individual consultant.
Results: Of 686 first time CABG operations between 01/04/2010 and 31/03/2011 LIMA to LAD was not used in 2.19% of cases. In 6 cases the patient was classified too high risk (emergency operation, anticoagulated patient). In 5 cases LIMA was deemed unusable due to poor flow, plaques, proximal bifurcation or small calibre. LIMA was damaged during harvest in 3 instances. There was one case where documentation was not clear whether LIMA graft was used or not.
Conclusion: Overall, LIMA use in James Cook University Hospital is above national average but clearer consensus guidance is required.

0426: DETECTION AND PREVENTION OF POST-OPERATIVE DELIRIUM–ARE WE FORGETTING THE GUIDELINES WITHIN CARDIOTHORACIC SURGERY?

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Aim: Post-operative delirium is a common complication within cardiothoracic surgery. Standards set by the British Geriatric Society suggest patients over 60 should be screened for cognitive decline prior to admission to identify those at high risk of developing the condition. This audit evaluated whether guidelines were being adhered to within a large teaching hospital.
Methods: Patients over 60 admitted for elective cardiothoracic surgery between March and June 2014 were included. A retrospective analysis of clinical records was conducted to identify if patients had evidence of pre-operative cognitive screening with an Abbreviated Mental Test (AMT).
Re-audit using the same criteria took place between September and December 2014.
Results: Initially 0% ($n = 88$) of patients had pre-operative screening for cognitive decline. Following this staff members involved with patient care participated in educational sessions surrounding the recognition and prevention of post-operative delirium. New domains were also added to pre-existing pre-operative proformas to include AMT testing.
Re-audit following these recommendations showed an increase in pre-operative screening of cognitive decline to 71% ($n = 49$).
Conclusion: Improving staff education and making changes to patients' pre-operative assessment helped increase compliance with national guidelines on the identification of patients at increased risk of developing post operative delirium within Cardiothoracic surgery.

0463: EUROSCORE: A MARKER FOR RESTERNOTOMY FOR BLEEDING POST CARDIAC SURGERY?

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Aim: Resternotomy for bleeding after cardiac surgery occurs in 1–4 % of patients. The standard and logistic European System for Cardiac Operative